

# The PRAIRIE ROSE

**NDNA**  
NORTH DAKOTA NURSES  
ASSOCIATION  
1912-2012

**Inside**

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## PRESIDENT'S MESSAGE

**Roberta Young, MSN, RN  
President NDNA**



**Roberta Young**

Ethical Practice-Quality Care is the ANA National Nurses Week Theme this year. The premise recognizes the importance of ethics in nursing and acknowledges the strong commitment, compassion and care nurses display in their practice and profession.

In North Dakota we currently have 13,474 Registered Nurses, 3,641 Licensed Practical Nurses, 1,138 with Advanced Practice Licenses and of those, 719 have Prescription Authority. (North Dakota Board of Nursing statistics, March 2015, [www.ndbon.org](http://www.ndbon.org)) This Nurses Week I would like to focus on the quality of nursing care we provide in our state in such a wide variety of settings. As nursing professionals we have the privilege to provide care for people of all ages, at many different points of their life. The North Dakota Board of Nursing (NDBON) 2013-2014 annual report lists the areas of employment, practice and position of nurses in our state. It is interesting to note the growth areas such as increases in ambulatory care and physician offices and those that have little growth year over year such as nursing home, home care and school nursing. Still the highest percentage of RNs (46%) practice in the hospital setting and the highest percent of LPNs (30%) work in Nursing Home or Long Term Care. (NDBON 2013-12014 Annual Report, pp 25-26).

I want us all to take a moment to acknowledge the value nursing brings to all points of the continuum of care. Most of our population will spend a vast majority of their lives not in a hospital, and manage their health with very little intervention. There are key touch points

though, in most people's life where nursing practice is very impactful.

A favorite speaker and author of mine, Joe Tye recently posted a blog regarding the care at the time of his father's death titled, "In Praise of the Underappreciated." He notes that, "Long-Term Care and Hospice nurses don't receive the glamor treatment from the media...but these professions are every bit as noble and the people who work in them are every bit as dedicated and competent at what they do." (Joe Tye, Spark Plug, March 3, 2015) I sent his posting to several friends who work in long term care, home care and hospice settings. Such an important part of health care that needs nurses to provide ethical and quality care. These nurses, learn and honor the story of the person and weave it into their care. I hope you know how important your contribution is.

Do you remember the names of the nurses who may have cared for you or your loved ones? My 92 year old father can still list the names of the hospice nurses who cared for my mom over 16 years ago. I can list the names of the nurses who were with me at the birth of my 5 children.

This Nurses Week please be intentional to recognize and thank peers that you hand off care too, that provide expertise to the collaborative care you give, who may go unrecognized, because the care they render is in the back ground. North Dakota Nurses, I thank you for your Quality and Ethical Care. You make Florence proud.

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### Writing for Publication in the Prairie Rose

The *Prairie Rose* accepts manuscripts for publication on a variety of topics related to nursing. Manuscripts should be double spaced and submitted electronically in MS Word to [director@ndna.org](mailto:director@ndna.org). Please write **Prairie Rose article** in the address line. Articles are peer reviewed and edited by the RN volunteers at NDNA. **Deadlines for submission of material for 2015 Prairie Rose are 3/19/15, 6/19/15, 9/18/15 and 12/18/15.**

Nurses are strongly encouraged to contribute to the profession by publishing evidence based articles. If you have an idea, but don't know how or where to start, contact one of the NDNA Board Members.

The *Prairie Rose* is one communication vehicle for nurses in North Dakota.  
 Raise your voice.

### The Vision and Mission of the North Dakota Nurses Association

**Vision:** North Dakota Nurses Association, a professional organization for Nurses, is the voice of Nursing in North Dakota.

**Mission:** The Mission of the North Dakota Nurses Association is to promote the professional development of nurses and enhance health care for all through practice, education, research and development of public policy.

# ANA/NDNA

Jamie Hammer is the Vice President for Practice, Education, Administration and Research. She is a nursing instructor at Minot State University, works in the Neonatal Intensive Care Unit at Trinity Health, and is a member of the Neonatal NorthStar flight team. She graduated with a BSN in 2005 from Minot State University and a MSN in 2012 from University of Mary. She is currently enrolled in the Doctorate of Nursing Practice: Educational Leadership Program. Jamie presently volunteers as the camp nurse at the YMCA Summer Camp and as a certified child passenger safety technician. She has a diverse nursing background which includes, medical/surgical, ICU, NICU, hospital supervisor, nurse manager, flight nursing, and education. "I want NDNA to be Leaders who help others achieve their highest potential in their nursing career. Nursing is an amazing career choice and the opportunities are endless."



Jamie Hammer

Carmen Bryhn, MSN, RN is the Director of State Affairs. Carmen also works at CHI St. Alexius on the Children's Unit in Bismarck, ND. She has a background in medical/surgical nursing as well as being a nursing instructor. She received her Master's degree in Nursing Administration from the University of Mary. "It is an honor to represent nurses in this state & be more involved with my peers on a professional level. I believe registered nurses in all practice areas & specialties must work together to advocate for each other & nursing itself as a profession."



Carmen Bryhn

## Ethical Practice, Quality Care: 1912-2015

**Donelle Richmond, BSN, RN-C**  
**Vice President - Finance, NDNA**

Ethical practice, quality care is the theme of ANA's 2015 National Nurses Week. As I researched and wrote this article I was repeatedly struck by how those same principles guided the work of nurses in North Dakota in the early 1900s. My original intent was to chronicle the early history of the North Dakota Board of Nursing (BON), as they near the celebration of their 100th anniversary. What I learned as I looked through old files, was that nursing was as collaborative a profession in its early days as it is now and the history of the Board of Nursing is not complete without some history of the American Nurses Association (ANA), the North Dakota Nurses Association (NDNA), the first hospitals in North Dakota, and the early schools of nursing in North Dakota thrown in to the mix. This article is a short walk through some of the early history of nursing in North Dakota.

First, though, I must acknowledge and thank two parties for starting me on this path and for providing a wealth of information. First, Wanda Rose, PhD, RN, BC, Associate Professor of Practice, NDSU Nursing at Sanford Health, who wrote an article in entitled "Public Protection: Regulation of Nursing Education in North Dakota." In it she chronicles how the BON was actually formed as a result of the lobbying efforts of the North Dakota State Nurses Association (NDSNA), now known as NDNA. I found it fascinating that 100 years ago nurses recognized the need for standardized nursing education and nursing practice. The second party I must thank is the State Historical Society of North Dakota. They have archived many of the early items that chronicle the history of both the BON and NDNA. For ease of writing I am not going to cite the source of every fact I mention, as there were hundreds. I did take thorough notes so if anyone is

interested in any particular details please contact me and I can direct you to the correct box and folder in the archives.

### ANA/NDNA

So let's begin. ANA was founded by several groups of nursing alumni in the United States and Canada. As they would gather for school reunions and share stories, they recognized the need for uniformity of preparation and practice, and thus formed the National Associated Alumnae of the United States and Canada in 1896. An organization of graduate nurses, they split into the two national organizations in 1909, and the United States group called their organization the American Nurses Association.

In April of 1911, some graduate nurses working in North Dakota began organizing a state association so they could be part of the national organization. At that time there were 15 schools of nursing in North Dakota. In December of 1911 the Grand Forks Graduate Nurses Association began searching for state wide interest, and on May 7, 1912 the North Dakota State Nurses Association was organized. There were 155 charter members, of which they kept an indexed list "with addresses written in pencil to allow for frequent moving." One of the first activities of NDSNA was forming a Committee on Education to begin establishing minimum education standards. NDNSA later incorporated on May 23, 1916. In the original article of incorporation it states: "the purpose of which said corporation is formed is and shall be with the object of raising of the standards of nurses and nursing education; the furtherance of the efficient care of the sick, and the promotion of all interests of the nursing profession."

The first annual meeting of NDSNA was held in April of 1913. At this meeting they adopted "A Basic Course of Study for Training Schools,"

*Ethical Practice continued on page 4*

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*Ethical Practice continued from page 3*

brought forth by their Committee on Education. At the second annual meeting in April of 1914, they drafted a bill asking the Legislature to set up a process by which graduate nurses practicing within the state could be regulated and licensed to practice, and establish standards for regulation of training schools. The bill, entitled "The Law Governing the Registration of Nurses and the Minimum Curriculum Required by the North Dakota State Board of Nurse Examiners," was passed in 1915, and became effective as the Nurse Practice Act on July 1, 1917.

The law provided "an act creating a board of nurse examiners, providing for the appointment of inspectors of training schools, and for the examination and regulation of graduate nurses, and exempting practical nurses from registration, and prescribing the course of study and standard for training schools ... Upon taking effect of this Act, the NDSNA at the annual meeting shall nominate and submit to the governor a list of ten graduated nurses from which appointment shall be made." The law also stated "A person who received his/her certificate according to the provisions of this act shall be known as a 'Registered Nurse.'" Later on in the law it clarifies the practical nurse exemption with "This Act shall not be construed to apply to gratuitous nursing of the sick by friends or members of the family, nor to any practical nurse or person nursing the sick for hire who does not pretend to be a registered nurse."

On June 8, 1915 ten nurse names were submitted by NDSNA to the Governor for the first Board of Nurse Examiners, including their top five recommendations. The top five were Alice Smith, an 1897 graduate who was Director of the Course for Nursing at UND; Jennie Mahoney, 1907 graduate working as a private duty nurse; Ethel Stanford, 1910 graduate working as a private duty nurse; Pearl Weed, 1912 graduate working as a private duty nurse; and Osa Oppedal, a 1906 graduate who had been the Superintendent of Nurses at St. Luke's and was also a private duty nurse. The Governor chose two of the top five, Jenny Mahoney and Pearl Weed, as well as Emma Schroeder, Mildred Clark, and Sister Laurentine to make up the first Board of Nurse Examiners.

**State Board of Nurse Examiners**

The first meeting of the State Board of Nurse Examiners of North Dakota was held on September 3, 1915. At this meeting it was motioned and carried to set up a meeting with the Education and Legislative Committees of NDSNA in order to secure their cooperation in the matter of deciding upon a curriculum to be used by the training schools of North Dakota. By 1918, there were 12 accredited hospital schools of nursing in North Dakota. Each one had their own curriculum that had been reviewed and approved by the

board. In October of 1919 the State Board of Nurse Examiners met with the education and executive committees of NDSNA and the superintendents of training schools in North Dakota. At that meeting it was motioned and carried that the "course of study recommended by the State Association be fitted to our use," thus standardizing the educational requirements to become a registered nurse in the state of North Dakota.

That course of study spelled out three rigorous years of very specific theoretical and practical study, along with approved reference books. Early on, state law only required students to have the equivalent of an eighth grade education before admission to a training school. Some individual schools had higher educational and even age requirements, but it wasn't until 1939 that state law required a high school diploma to attend nursing school. I found it interesting (and humorous) that included in the first year's studies was: "Practical work to include the proper methods of preparing and serving coffee, tea, albumen, baked apples, lamb chops, game, halibut, oatmeal, French salad dressing, cooked salad dressing, and mayonnaise!" Students were allowed three weeks of vacation during the first and second year.

Board members were paid \$5.00/day "while actually engaged in the performance of the duties of the office." They also received expenses of \$2.00/day for lodging, \$1.50/day for meals, and railroad fare with Pullman accommodations.

According to the 1918 report issued by the board, there were 396 nurses registered under waiver (or grandfathered in), and 55 nurses registered by examination. The roster listed the certificate number, name and school of nursing. The first certificate of registration was for a Miss Erdman (no first name or school listed). The second and third certificates went to Annabel Mae Foss and Roxy L. Foss, both graduates of Bismarck Hospital. Most of the nursing schools listed were in North Dakota, but there were also schools from Minnesota, Illinois, Iowa, Kansas, Massachusetts, Washington, Wisconsin, Missouri, Texas, South Dakota, New York, Michigan, London England, Copenhagen Denmark, and Brunner Switzerland.

**Hospitals and Training Schools**

The next path I am going to take you down is a history of the early hospitals in North Dakota, along with their training schools for nursing. All of this information was found in an archived paper entitled "Women in White' March across the North Dakota Prairies." It was a thesis submitted to UND by Sister Carita Bower in June of 1950 as part of the required coursework for her Masters of Science in Education.

The first hospital in Dakota Territory was founded in Bismarck in 1884 by the Benedictine Sisters of St. Joseph, MN, who had come to Bismarck in 1874. They purchased a brick

building on 6th and Main which had just been built for a hotel called the Lamborn. The Right Reverend Alexius Edelbrock, OSB negotiated the purchase of the building (thus securing naming rights in the process!). By 1915 they had outgrown their original space and built a new hospital at 311 9th St. It was at this time that they opened a training school for nurses. There were 12 students in the first class, 11 of whom graduated.

Ground was broken for North Dakota's second hospital on September 15, 1891 in Grand Forks. Opening its doors on January 3, 1892, St. Luke's was privately owned by Dr. JE Engstad. Due to financial constraints, Dr. Engstad sold the hospital on December 1, 1899 to the Grand Forks Deaconess Hospital Corporation, at which time the name was changed to Grand Forks Deaconess Hospital. The hospital corporation was founded by Rev. I. Tollefson who organized the Lutheran communities in Grand Forks to raise the \$12,000.00 necessary to make the purchase. The minutes of the corporation meetings were kept in Norwegian. Grand Forks Deaconess Hospital opened the second school of nursing the following June.

Devils Lake opened the third hospital in 1895. Founded by the Sisters of Mercy, it was originally called St. Vincent DePaul Hospital, with the name later being changed to Mercy Hospital.

In 1899 the Right Reverend John Shanley, Bishop of Fargo, reconstructed his old residence at Island Park in Fargo into a hospital. St. John's Hospital opened on April 17, 1900 and was run by the Sisters of St. Joseph of Carondelet. They opened the first training school for nurses in North Dakota 1901. There were 2 students in the first class, graduating in 1904. Classes were one to two lectures a week given by the medical doctors, classes on nursing held for one hour daily, and then ten (yes 10) hours on duty every day. St. John's later built a new hospital in 1904.

Northwood Deaconess Hospital opened its doors in October 1902. The Northwood Deaconess Training School for Nurses opened on November 1, 1909. There were 5 students enrolled in a two year program. First year classes included Care of Souls and Norwegian Grammar.

Grafton Deaconess Hospital was the next hospital in North Dakota, opening its doors in February of 1903. St. Michael's Hospital in Grand Forks opened on December 11, 1907. Run by the Sisters of St. Joseph of Carondelet, they opened a training school on January 1, 1908 with 3 students enrolled in a three year program.

St. John's Hospital in Kenmare opened in 1908, along with a three year training school. St John's changed its name to Lakeside Hospital in 1918, and eventually to Kenmare Deaconess Hospital in 1922. General Hospital in Devils Lake opened on June 15, 1908. The General Hospital Training School for Nurses opened on September 8th of that same year with 4 students enrolled in a two year program.

St. Luke's Hospital in Fargo opened in February of 1908 under the auspices of the Lutheran Hospital Association. The St Luke's Hospital Training School for Nurses opened in 1908, with 3 students enrolled in their two year course. The first student nurse's government association known in the state was founded by the St. Luke's students in 1923.

Bismarck Evangelical Hospital opened on February 2, 1909 with 12 students enrolled in a three year program. This later became Bismarck Hospital. Mandan Deaconess Hospital also opened in 1909 along with a training school for nurses. Good Samaritan Hospital in Rugby opened its doors and training school in 1910 with 4 students enrolled in a three year program. St. Joseph's hospital in Minot opened in March of 1911 with 5 students enrolled in a two year program.

November of 1913 brought the opening of Parkview Hospital in Jamestown. Their training school for nurses had 4 students in a 3 year program. In 1917 the hospital was purchased by the Sisters of St. Joseph of Carondelet, and the name was changed to Trinity Hospital.

By the time Sr. Bower wrote her paper in 1950, several of these hospitals and schools of nursing had already closed, and more have followed since. Even though the hospitals and schools have changed, and the organizational mission statements have evolved, the ethical practice and quality care that were the foundation of nursing in our great state are still alive and well today. Thanks for walking with me.



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# Nursing Student Association of North Dakota



Shown above are Carmen Bryhn, Director of State Affairs, Donelle Richmond, Vice President of Finance, Tammy Buchholz, Vice President of Membership, & Jamie Hammer, Vice President of Practice, Education, Administration, & Research

The North Dakota Nurses Association was honored to be invited to the Nursing Student Association of North Dakota's Annual Convention at the end of January. The theme of the convention was "Reinvent to Prevent #2020" & over 150 nursing students filled the convention center at the Sleep Inn & Suites in Minot. Judging of the Student Nurse of the Year & the Student Nurse Leadership Award were activities that NDNA participated in. The North Dakota Nurses Association board members also presented a breakout session educating the student nurses about the history, benefits & furthering their professionalism with NDNA upon graduation. NDNA would like to congratulate the winners of our door prizes: Kristin Kielshus (MSU), Kimberly Ness (UND), Hannah Houle (UMary), Charys Kunkel (NDSU Bismarck, Faculty), Kristen Bortke (NDSU, Bismarck), Haley Heiser (MSU), Alex Lovgren (NDSU Bismarck), Jordan Taghen (NDSU Bismarck), Katie Knopp (WSC). And our Grand Prize winner of the FREE ONE YEAR MEMBERSHIP UPON BOARD COMPLETION: Payton Bond! Congratulations to all our winners and we hope to see you next year!

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**100 YEARS**  
 OF NURSING EXCELLENCE:  
**PAST, PRESENT, AND FUTURE**  
 May 21 | 2015 | Bismarck, ND

On behalf of the North Dakota Board of Nursing and the North Dakota Center for Nursing, we would like to invite you to our upcoming celebration entitled *Celebrating 100 years of Nursing Excellence: Past, Present and Future*. The celebration will be held at the Heritage Center and the State Capitol Building on May 21, 2015. The board and center partnered with the overall goal to increase team building, recognition and commitment to the work of the Center for Nursing while increasing the visibility of the ND Center for Nursing through an annual celebration that will over time serve as an annual fundraiser.

#### PROCLAMATION & NURSES DAY

Governor Jack Dalrymple signed a proclamation which proclaimed February 2015 Board of Nursing Month. Board Members along with Board Staff and Lieutenant Governor Drew Wrigley attended the proclamation. Board Members and staff celebrated on March 11, 2015 with NDCFN during Nurses Day at the Legislature.

#### HISTORY

The State Board of Nursing grew out of the Board of Nurse Examiners which was created in 1915. The purpose of the Board was to provide for exams, to grant and issue certificates of registration, and to inspect and accredit schools

of nursing. The composition of the board, length of terms, qualifications and powers and duties changed many times in the one hundred years.

#### CELEBRATION

This event is the capstone of a year marking the 100th anniversary of the North Dakota Board of Nursing. During the celebration we will have speakers and exhibits from the past, present and future of nursing along with a gala reception featuring awards from both the North Dakota Board of Nursing and the North Dakota Center for Nursing. We encourage you to attend this event. We would like to invite you to provide and exhibit historical nursing artifacts from your region of the state. These could include pictures, uniforms, caps, books, stethoscopes, and any other nursing artifact. We are excited about this historical event and the opportunity to share the past accomplishments of nurses in ND, while looking towards the future. Celebration Website: <http://events.r20.constantcontact.com/register/event?oeidk=a07ea1f0xz768572f7f&llr=9d8hgejab>

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# Nurses Day at the Legislature

On Wednesday, March 11th, over 250 nurses and student nurses descended upon the State Capitol to participate in the legislative process. The event was hosted by the North Dakota Center for Nursing and sponsored by the North Dakota Board of Nursing and the North Dakota Nurses Association.

We packed the committee rooms and hallways, browsed booths set up by over a dozen different nursing organizations, and toured the Capitol building.

There were many healthcare related bills being discussed that day – from Community Paramedic Reimbursement to Telemedicine to Insurance Coverage for Oral Chemotherapy and many more. Some nurses took advantage of being present and were able to testify during the public hearings of legislative committees. Others were able to sit with a legislator during the floor votes in the afternoon.

Overall, it was a very successful day of advocacy!



## Promoting RN Health, Safety, and Wellness



Are you a healthy nurse and a role model for wellness? Too often, RNs neglect their own care and health, forgetting to take the advice they give their patients. Stress, fatigue, poor diet, lack of exercise and time, as well as occupational

health risks, threaten nurses' health on a daily basis. RNs need to practice self-care to ensure they are at their optimal health level. The American Nurses Association (ANA) defines a healthy nurse "as one who actively focuses on creating and maintaining a balance and synergy of physical, intellectual, emotional, social, spiritual, personal and professional wellbeing. A healthy nurse lives life to the fullest capacity, across the wellness/illness continuum, as they become stronger role models, advocates, and educators, personally, for their families, their communities and work environments, and ultimately for their patients." Furthermore, ANA has developed the following HealthyNurse constructs:

### Priority to Self-Care

- *Self-care and supportive environments enable the nurse to increase the ability to effectively manage the physical and emotional stressors of the work and home environments.*

### Opportunity to Role Model

- *The healthy nurse confidently recognizes and identifies personal health challenges in themselves and their patients; enabling them and their patients to overcome the challenge in a collaborative, non-accusatory manner.*

### Responsibility to Educate

- *Using non-judgmental approaches, considering adult learning patterns and readiness to change, nurses must empower others by sharing health and safety knowledge, skills, resources, and attitudes.*

### Authority to Advocate

- *Nurses are empowered to advocate on numerous levels, including personally, interpersonally, within the work environment and the community, and at the local, state, and national levels in policy development and advocacy.*

To assist RNs on their wellness journeys, ANA, in collaboration with Pfizer Inc, created a health risk appraisal (HRA). This HRA assists participants in identifying their health, safety, and wellness risks personally and professionally. The HRA is divided into three general categories: demographics, occupational health, and health/safety/wellness. Participants can compare their personal results against ideal standards and national averages. Participants can also access an interactive web wellness portal for further resources. A heat graph allows participants to easily evaluate their results: red denotes high risk, yellow medium risk, and green low to no risk. It takes approximately twenty minutes to complete the HRA. Participation in the HRA will help to build a unique nurse-specific personal and occupational health-related aggregated data base. Secure and HIPAA-compliant, the HRA is free and available to all RNs and nursing students. Take the HRA today at [www.anahra.org](http://www.anahra.org)!

### Calling to Care

- *Caring is the interpersonal, compassionate offering of self, as nurses build relationships with their patients and their families, while helping them meet their physical, emotional, and spiritual goals, for all ages, in all health care settings, across the care continuum.*

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# The Year of Ethics Commences with First Revision of Code Since 2001

## ANA Plans Ethics Educational Activities for 2015 to Highlight Importance in Nursing Practice

SILVER SPRING, MD – Making decisions based on a sound foundation of ethics is an essential part of nursing practice in all specialties and settings. In recognition of the impact ethical practice has on patient safety and the quality of care, the American Nurses Association (ANA) has designated 2015 as the “Year of Ethics” highlighted by the release of a revised code of ethics for the profession.

“The public places its faith in nurses to practice ethically. A patient’s health, autonomy and even life or death, can be affected by a nurse’s decisions and actions,” said ANA President Pamela F. Cipriano, PhD, RN, NEA-BC, FAAN. “ANA believes it’s important that all nurses practice at the highest ethical level, and therefore, we will be offering a full range of activities to inform and support nurses to achieve that goal in a stressful and ever-changing health care environment.”

A December Gallup survey ranked nurses as the top profession for honesty and ethical standards for the 13th consecutive year.

The foundation of the 2015 ethics initiative is the revised *Code of Ethics for Nurses with*

*Interpretive Statements*, which was released Jan. 1. Several thousand registered nurses submitted comments during a four-year revision process for the new *Code of Ethics*, which was last updated in 2001. The update ensures that the Code reflects modern clinical practice and evolving conditions, and fully addresses transformations in health care.

Activities emphasizing the importance of ethics in nursing practice include:

- A Jan. 21 live webinar, “Keeping the Code: Every Nurse’s Ethical Obligation,” with other webinars planned throughout the year.
- The National Nurses Week theme, “Ethical Practice. Quality Care,” May 6-12.
- The 2015 ANA Ethics Symposium designed to facilitate dialogue across the nursing spectrum, June 4-5 in Baltimore.
- Publication of the *Guide to the Code of Ethics for Nurses*, scheduled for a July release.

In 2014, ANA participated as a strategic partner in the National Nursing Ethics Summit convened by the Johns Hopkins University’s

Berman Institute of Bioethics and School of Nursing to strengthen ethics in the profession. The summit resulted in the Blueprint for 21st Century Nursing Ethics: Report of the National Nursing Summit. Summit leaders are encouraging individuals and organizations to adopt and implement the ethics blueprint to “create and support ethically principled, healthy, sustainable work environments; and contribute to the best possible patient, family and community outcomes.”

*ANA is the only full-service professional organization representing the interests of the nation’s 3.1 million registered nurses through its constituent and state nurses associations and its organizational affiliates. ANA advances the nursing profession by fostering high standards of nursing practice, promoting the rights of nurses in the workplace, projecting a positive and realistic view of nursing, and by lobbying the Congress and regulatory agencies on health care issues affecting nurses and the public.*

## National Nurses Week History



National Nurses Week begins each year on May 6th and ends on May 12th, Florence Nightingale’s birthday. These permanent dates enhance planning and position National Nurses Week as an established recognition event. As of 1998, May 8 was designated as National Student Nurses Day, to be celebrated annually. And as of 2003, National School Nurse Day is celebrated on the Wednesday within National Nurses Week each year.

The nursing profession has been supported and promoted by the American Nurses Association (ANA) since 1896. Each of ANA’s state and territorial nurses associations promotes the nursing profession at the state and regional levels. Each conducts celebrations on these dates to recognize the contributions that nurses and nursing make to the community.

The ANA supports and encourages National Nurses Week recognition programs through the state and district nurses associations, other specialty nursing organizations, educational facilities, and independent health care companies and institutions.

### A Brief History of National Nurses Week

- 1953** – Dorothy Sutherland of the U.S. Department of Health, Education, and Welfare sent a proposal to President Eisenhower to proclaim a “Nurse Day” in October of the following year. The proclamation was never made.
- 1954** – “National Nurse Week” was observed from October 11-16. The year of the observance marked the 100th anniversary of Florence Nightingale’s mission to Crimea. Representative Frances P. Bolton sponsored the bill for a nurse week. Apparently, a bill for a “National Nurse Week” was introduced in the 1955 Congress, but no action was taken. Congress discontinued its practice of joint resolutions for national weeks of various kinds.

- 1972** – Again a resolution was presented by the House of Representatives for the President to proclaim “National Registered Nurse Day.” It did not occur.
- 1974** – In January of that year, the International Council of Nurses (ICN) proclaimed that May 12 would be “International Nurse Day.” (May 12 is the birthday of Florence Nightingale.) Since 1965, the ICN has celebrated “International Nurse Day.”
- 1974** – In February of that year, a week was designated by the White House as “National Nurse Week”, and President Nixon issued a proclamation.
- 1978** – New Jersey Governor Brendon Byrne declared May 6 as “Nurses Day.” Edward Scanlan, of Red Bank, N.J., took up the cause to perpetuate the recognition of nurses in his state. Mr. Scanlan had this date listed in Chase’s Calendar of Annual Events. He promoted the celebration on his own.
- 1981** – ANA, along with various nursing organizations, rallied to support a resolution initiated by nurses in New Mexico, through their Congressman, Manuel Lujan, to have May 6, 1982, established as “National Recognition Day for Nurses.”
- 1982** – In February, the ANA Board of Directors formally acknowledged May 6, 1982 as “National Nurses Day.” The action affirmed a joint resolution of the United States Congress designating May 6 as “National Recognition Day for Nurses.”
- 1982** – President Ronald Reagan signed a proclamation on March 25 proclaiming “National Recognition Day for Nurses” to be May 6, 1982.
- 1990** – The ANA Board of Directors expanded the recognition of nurses to a week-long celebration, declaring May 6 -12, 1991, as “National Nurses Week.”
- 1993** – The ANA Board of Directors designated May 6 -12 as permanent dates to observe “National Nurses Week” in 1994 and in all subsequent years.
- 1996** – The ANA initiated “National RN Recognition Day” on May 6, 1996, to honor the nation’s indispensable registered nurses for their tireless commitment 365 days a year. The ANA encourages its state

- and territorial nurses associations and other organizations to acknowledge May 6, 1996 as “National RN Recognition Day.”
- 1997** – The ANA Board of Directors, at the request of the National Student Nurses Association, designated May 8 as “National Student Nurses Day.”

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# Advance Care Planning Part II Inception of Honoring Choices North Dakota®

by Nancy Joyner, APRN-CNS, ACHPN® and  
Sally May, RN, BSN, CH-GCN

“Even though death is very much part of the cycle of life and the journey to physical dying begins with the inception of living, thinking and talking about one’s own death usually remains in the background, at least until its prospect becomes more probable or imminent (IOM, 2014, p. 12)”

“It’s always too early, until it’s too late.  
—The Conversation Project, 2013

## Introduction

During the late 20th century, medical treatment and technology in the United States created a condition that prolonged life expectancy, which has created distorted boundaries between life and death. Evidence has shown that the care people would choose when they are facing end of life is often different from the care they actually receive, with many receiving aggressive treatment

they did not want. Despite considerable progress, significant problems remain in providing high-quality and compassionate end-of-life care for Americans while honoring their wishes (Volandes, 2015, Guwande, 2014, IOM, 2014, NHDD website, The Conversation Project website).

Currently, most people in the United States have no documentation of their wishes regarding end-of-life care, and few have discussed advance care planning with either their family or health care provider. A 2013 national survey by the Conversation Project of nearly 2,100 Americans age 18 and older revealed that while 90 percent believed that having family conversations about their wishes regarding end of life care was important, fewer than 30 percent had actually had these conversations (Conversation Project, 2013). Generally speaking, individuals do not consider the possibility of experiencing a serious accident or illness that leaves them unable to speak for themselves though, in fact, most individuals at the end of life are neither physically, mentally, or cognitively able to make their own decisions about

care. Family, friends, and healthcare providers are left not knowing an individual’s wishes or personal beliefs regarding starting, continuing or withdrawing medical treatments (Guwande, 2014, IOM, 2014, Volandes, 2015). Compounding the current state of end-of-life care is that the majority of these patients will receive acute hospital care from physicians who do not know them. Advance care planning conversations are essential to ensure that patients receive care reflecting their values, goals, and preferences (IOM, 2014, p.172). Though no North Dakota specific data is available, the anecdotal experience of families and health care providers suggests that the lack of advance care planning conversations remains a significant issue in North Dakota as well.

## Advance Care Planning in North Dakota: The Beginning

The need to improve advance care planning and end-of-life care in North Dakota was legally addressed when the right and responsibility of adults to make decisions about their own health care, i.e., create a health care directive, became law in 1991 (North Dakota Century Code, 2014).

Led by the North Dakota Medical Association, the Matters of Life and Death Project, involving a variety of organizations and individuals in North Dakota, made a concerted effort from 1999 to 2003 to improve end-of-life care in North Dakota. These efforts included encouraging advance care planning conversations, providing end-of-life care education for healthcare providers, and bringing the topic of advance care planning to the attention of communities across North Dakota. The advance health care planning guide created by the Matters of Life and Death Project titled *Who Will Speak for You If You Can’t Speak for Yourself?* is available on the North Dakota Medical Association’s website (<http://ndmed.org/>).

A renewed interest in advance care planning and end-of-life care has developed in North Dakota related to the increased attention given to reducing potentially avoidable hospitalizations including admissions and readmissions. According to a landmark national study published in 2009, one fifth of Medicare beneficiaries hospitalized from 2003-2004 were rehospitalized within 30 days, and more than one third were rehospitalized within 90 days. Two thirds of the beneficiaries who were hospitalized for a medical condition were either rehospitalized or died within the first year after discharge (Jenks, 2009). The findings of a 2013 study indicate that more persons aged 65 years and older were dying at home versus the hospital but the rate of intensive care use in the last month of life had actually increased, with nearly 30% of decedents receiving intensive care in the last months of life in 2009. Another indicator of change in end-of-life medical care is that nearly 12% of decedents had three or more hospitalizations in the last 90 days of life. Hospice use had increased but, approximately 28% of those decedents used a hospice for 3 days or less in 2009 (Teno, 2013). Along with healthcare delivery changes, advance care planning has demonstrated the ability to improve end-of-life care and patient and family satisfaction (Detering, 2010).

In 2013, the North Dakota Medical Foundation reignited the dormant efforts of the Matters of Life and Death Project to improve advance care planning efforts by enquiring the possibility of North Dakota Health Care Review, Inc. (NDHCRI), subsequently renamed Quality Health Associates of North Dakota (QHA), in reorganizing and facilitating a statewide advance care planning initiative. Because of the readmission reduction work that NDHCRI was already doing and the recognized correlation between hospital readmissions and end-of-life care, NDHCRI made the decision to facilitate a statewide initiative to improve advance care planning in North Dakota.

In the spring of 2013, 12 individuals from various organizations and disciplines, several from the original 2003 North Dakota Matters of Life and Death Project, joined the effort to improve advance care planning in North Dakota. Through a series of conference calls and face-



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**Advance Care Planning continued from page 8**

to-face meetings, partners of the North Dakota Advance Care Planning (NDACP) initiative discussed the necessity of creating a sustainable organization which would require community-wide collaboration, an effective communication strategy, and an education plan for healthcare providers and the public. The partners also recognized that this ambitious effort would require the support of individuals, organizations, health systems and agencies from across North Dakota.

The initial action of the NDACP partners was to describe the future state of “improved” care planning in North Dakota, i.e., what it meant for healthcare providers, for individuals and their families. How would the future state of advance care planning be different than the current experience of individuals?

**Vision:**

*To create a culture across ND where continuous (on-going) advance care planning is the standard of care and every individual's informed preferences for care are documented and upheld.*

The vision statement shaped the starting point for the North Dakota Advance Care Planning (NDACP) coalition. Creating a culture across ND where continuous advance care planning that is the standard of care requires the efforts and passion of many individuals from different organizations, backgrounds, and experiences. Jody Ward describes the importance of collaboration as “having a shared voice in ND which is important for the good of all North Dakotans. Together efforts will develop into a statewide system of communication around care planning.” She goes on to explain, “it is communities and partners coming together to have a culture of shared thinking on the topic of end of life. Having a shared voice among communities and professionals has been successful in other areas such as improving care for stroke and heart attack patients. This topic is just as important and serving all areas of ND is important.” (Jody Ward MS, RN, APHN is the Senior Project Coordinator for the Center for Rural Health-University of North Dakota School of Medicine and Health Sciences in Minot).

Attempting a culture change is a big endeavor and has many obstacles. Debbie Anderson believes, “we have a start and a vision but we have a long way to go before the majority of people truly understand what advance healthcare planning is and why it is important for everyone, not just the aging person.” (Debbie Anderson, MS, LPC, NCC, is the Director Social & Behavioral Services, Case Management & Wellness in the Valley, Mercy Hospital of Valley City). Debbie Kirchoffner confirms this by saying that she feels advance care planning is fragmented and it is still not at the forefront of discussions. (Debbie Kirchoffner, LSW, is the Palliative Care/Care Coordinator, Essentia Health, Fargo).

Debbie Kirchoffner also states that with her work in palliative care she sees how helpful advance care planning can be if a patient has completed a healthcare directive. This supports the second portion of the vision statement that “every individual's informed preferences for care are documented and upheld.”

One of the community representatives, Karen Robinson, RN, PhD, (Fargo), firmly believes that the individuals involved in Honoring Choices North Dakota® are truly committed to this important work. She says, “one can just feel the group's excitement and enthusiasm at the meetings; each member wants to do everything they can to improve the end of life experience of the people of North Dakota.”

Once the vision statement was crafted, the discussion turned to the mission of NDACP, i.e., the purpose of the initiative. What would be the role of NDACP if the future state of advance care planning in North Dakota was to be realized?

**Mission/Goal:**

*To assist statewide community partners with the development and implementation of a comprehensive advanced care planning program.*

As a volunteer and newly formed coalition of partners, the North Dakota Advance Care Planning initiative required the help of many passionate and enthusiastic people. Judith Peterson relates, “we are in the infancy stage, but there are many health care organizations from

our communities who are interested in promoting this and are making changes already, developing programs to accommodate and supporting the work that is currently being done.” (Judith Peterson is a social worker and the Clinical Education Supervisor at Hospice of the Red River Valley in Fargo).

With the development of the vision and mission statements, the North Dakota Advance Care Planning partners addressed the logistics of how the future state of advance care planning would be realized. Six objectives were the result of that discussion.

**Objectives:**

1. *Establish a statewide collaborative to promote advance care planning conversations and documentation of preferences for care.*
2. *Create a culture where end-of-life conversations become the norm through community and professional education, outreach and discussion forums.*
3. *Provide continuous advance care planning with the understanding that complex decisions must be based on the clinical context and the evolving goals of care and needs of individuals*
4. *Develop a standardized form that integrates individual preferences into medical orders.*
5. *Utilize a standardized mechanism for making documented preferences accessible across care settings*
6. *Identify core competencies for health professionals related to advance care planning by:*
  - a. *Developing an educational plan for practicing health professionals.*
  - b. *Integrating these competencies into the curriculum of educational programs across the state.*

**Advance Care Planning in North Dakota: The Progress**

In 2014, the North Dakota Advance Care Planning (NDACP) partners determined which of the six developed objectives were the immediate priorities. Corresponding workgroups were organized to develop plans of action for these four objectives.

The workgroup assigned to the first objective of NDACP, i.e., “to establish a statewide collaborative to promote advance care planning conversations and documentation of preferences for care,” was given the duty of determining in which North Dakota organization would the work of NDACP be housed.

Numerous North Dakota organizations were interviewed regarding their interest and ability in managing an advance care planning effort and being the home for such work. Organization characteristics considered were: the organization's mission statement and goals; its current capabilities; current projects related that aligned with advance care planning; available technology; potential financial support; sustainability; and geographic location. The advantages and disadvantages of each organization were discussed. The NDACP partners made the decision to have North Dakota Health Care Review, Inc. (NDHCRI) house and manage the work of NDACP recognizing the strategic relationship that NDHCRI had with the University of North Dakota Center for Rural Health.

The workgroup given the responsibility of the second objective of creating “a culture where end-of-life conversations become the norm through community and professional education, outreach and discussion forums” reviewed community and public awareness of advance care planning and the importance of having an advance care planning conversation. They explored the current research on ACP conversations including marketing and education strategies, developing an ACP culture, and funding opportunities.

Lois Ustanko, RN, MSN, relates, “There are some providers who are so appreciative about the opportunity to refer patients and family members to an advance care planning facilitator and others who are hesitant to turn to the preferences for care conversation even when the patient self-enrolled in a group education session.” (Lois Ustanko, RN, MS is the Director of Health Ministries at Sanford Fargo).

The third objective of providing “continuous advance care planning with the understanding that complex decisions must be based on the

clinical context and the evolving goals of care and needs of individuals” was the responsibility of the workgroup that also conducted the research regarding an organizational home for NDACP. Extensive data was collected by this workgroup in order to determine the advance care planning program that would best match the needs and culture in North Dakota. Numerous nationally recognized programs were evaluated including The Conversation Project, Caring Connections, Having the Conversation, Honoring Choices MN®, Respecting Choices®, and the U. S. Department of Veterans Affairs' ACP program. The extensive review of each program's characteristics included: the design of the program; method of delivery; target audience; evidence-base; alignment with the goals of NDACP; ease of adoption and adaptation; initial and on-going costs; timeframe for implementation; geographic considerations; curriculum standards; and any advantages and disadvantages discovered during the search. The NDACP partners made the decision that Honoring Choices Minnesota was the best fit for improving advance care planning in North Dakota.

A workgroup is also actively working on the fourth objective which is to “develop a standardized form that integrates individual preferences into medical orders.” The work involves the creation of a standardized end-of-life medical order form reflecting an individual's preferences for care that could be used throughout the state. Currently there is no standardized out-of-hospital DNR (Do Not Resuscitate) order other than what is used by hospice programs. The workgroup explored the POLST (Physician Orders for Life Sustaining Treatment) and other out-of-hospital DNR orders. The workgroup recommended staying with POLST which had been trialed in several North Dakota communities. The workgroup continues to revise the current version of ND POLST form and plans to develop a statewide education plan.

**Advance Care Planning in North Dakota: Honoring Choices North Dakota®**



The name “Honoring Choices North Dakota” is used under license from East Metro Medical Society Foundation.

*Advance Care Planning continued on page 10*

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## Advance Care Planning continued from page 9

In the fall 2014, NDACP officially became Honoring Choices North Dakota® and is currently in the process of becoming a North Dakota registered nonprofit charitable organization. The steering committee was elected from the membership at large and recently transitioned to a board of directors, with officers to be elected in the near future. The Honoring Choices North Dakota® (HCND) board of directors are as follows:

1. Judy Beck, Quality Health Associates of North Dakota, Minot – Supporting Organization
2. Lynette Dickson, UND Center for Rural Health, Grand Forks – Supporting Organization
3. Kathy Evenson, Hillsboro – Community Partner
4. Cindy Gohner, BCBS of North Dakota, Fargo – Third Party Payer
5. Nancy Joyner, Nancy Joyner Consulting, P.C., Grand Forks – Nurse/Subject Matter Expert
6. Courtney Koebele, North Dakota Medical Association, Bismarck – Legal, sponsoring organization/agent for Honoring Choices ND®
7. Judith Peterson, Hospice of the Red River Valley, Fargo – Hospice
8. Shelly Peterson, North Dakota Long Term Care Association, Bismarck – Long Term Care
9. Karen Robinson, Fargo – Community Partner

10. Kristina Schlecht, UND Center for Family Medicine, Minot – Physician

11. Lois Ustanko, Sanford Health, Fargo – Hospital.

As of March 2015, Honoring Choices North Dakota® had nearly 80 members with representation from over 40 organizations, including the major health systems, state agencies, community representatives and individuals, who are interested or passionate about improving ACP in North Dakota. The members are physicians, nurses, social workers, chaplains, attorneys, paramedics/EMTs, business and other relevant professions.

### Summary

Advance care planning is a process and Honoring Choices ND® hopes to lead the culture change in North Dakota. With Honoring Choices ND®, advance care planning will be developed with evidence-based tools used in all patient care settings, i.e. hospital, skilled nursing facilities, home care, clinics, hospice, etc., across North Dakota. Honoring Choices ND® will enable all health professionals to speak with patients and family members using a consistent approach and a common language. Karen Robinson firmly believes that the individuals involved in Honoring Choices North Dakota® are truly committed to this important work. She says, “one can just feel the group’s excitement and enthusiasm at the meetings; each member wants to do everything they can to improve the end of life experience of the people of North Dakota.” (Karen is a community member from Fargo.)

“Clinicians need to recognize the multiple barriers to effective communication on these issues, initiate the conversation themselves, and take time and make the effort to ensure that patient and family decisions are made with adequate information and understanding (IOM, p. 173).”

**For more information** about Honoring Choices North Dakota® or how you could support this important work, contact:

Sally May, RN, BSN, CH-GCN  
Honoring Choices North Dakota  
Quality Health Associates of North Dakota  
3520 North Broadway  
Minot, ND 58703  
Phone: 701.852.4231  
Fax: 701.857.9755  
Email: [smay@qualityhealthnd.org](mailto:smay@qualityhealthnd.org)

For additional information regarding the importance of Advance Care Planning (ACP):

- Agency for Healthcare Research and Quality – <http://www.ahrq.gov/research/findings/factsheets/aging/endliferia/index.html>
- American Academy of Hospice and Palliative Medicine (AAHPM) -<http://aahpm.org/issues/advance-care-planning>

- American Geriatrics Society (AGS) [http://www.americangeriatrics.org/files/documents/Adv\\_Resources/AGS.Statement.on.Advance.Care.Planning.042014.pdf](http://www.americangeriatrics.org/files/documents/Adv_Resources/AGS.Statement.on.Advance.Care.Planning.042014.pdf)
- American Medical Association- <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2191.page?>
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- The Center for Disease Control (CDC) <http://www.cdc.gov/aging/pdf/advanced-care-planning-critical-issue-brief.pdf>
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- The National Cancer Institute- <http://www.cancer.gov/cancertopics/cancerlibrary/epco/selfstudy/module-13/module-13-pdf>
- The National Coalition for Hospice and Palliative Care [http://www.nationalcoalitionhpc.org/?page\\_id=16](http://www.nationalcoalitionhpc.org/?page_id=16)
- The National Institute on Aging <http://www.nia.nih.gov/health/publication/advance-care-planning>
- National Hospice and Palliative Care Organization (NHPCO) <http://www.nhpc.org/advance-care-planning>
- National Healthcare Decisions Day <http://www.nhdd.org/>
- National POLST <http://www.polst.org/http://www.polst.org/>

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# Faith Community Nursing: Restoring a Ministry of Caring in the Church

by Lois Ustanko, RN, MSN  
March 2015

Throughout scripture, God calls people of faith to healing. For example 3 John 1:2 (New International Version) says, "Dear friend, I pray that you may enjoy good health and that all may go well with you, even as your soul is getting along well." The Reverend Dr. Granger Westberg developed parish nursing in the 1960s to reinstate outreach work that had been done in churches by religious orders in Europe and America in the 1800's (Westberg, 1990). Today, nursing performed within churches is called *Faith Community Nursing (FCN)* according to the scope and standards of practice set forth for this nursing specialty (American Nurses Association & Health Ministries Association [HMA & ANA], 2012). Faith Community Nursing (FCN) has evolved into the largest contingent of community-based nurses with more than 15,000 nurses involved in this ministry in the United States (International Parish Nurse Resource Center [IPNRC], 2011). Locally more than 1700 nurses are alumni of the Concordia College *Parish Nurse Preparation* course. These nurses promote health within the context of values, beliefs, and practices of the faith community (IPNRC, 2011). Providing care with compassion, respect, and presence is a hallmark for faith community nurses; characteristics which provide support for congregants that exceed traditional health interventions (Patterson & Slutz, 2011). King & Pappas-Rogich (2011) established faith community nurses as viable partners for promoting health improvement in communities.

With an increase in the aging population and higher costs of health care, one of the biggest challenges of this century is improving health outcomes for individuals living with chronic conditions. FCNs that treat individuals holistically are in an optimal position to influence behavioral change and empower them to take charge of their personal health (King & Pappas-Rogich, 2011).

## Services Delivered by Faith Community Nurses

The goal of faith community nursing is to protect, promote, and maximize health and capabilities, prevent illness and injury, and respond to suffering within the context of the values, beliefs, and practices of the faith community (ANA & HMA 2012). The traditional roles of this nurse include being a health educator, health counselor, health advocate, and referral agent (IPNRC, 2011). In addition to the traditional roles it is important to add new practices for FCN that include the facilitation of physical functioning, promoting lifestyle changes, and the appropriate use of the health care system. The additional roles are a revised paradigm of this nursing specialty and are being suggested by Solari-Twadell & Hackbarth (2010)

The Faith Community Nursing program at Sanford Health Fargo recently celebrated its 15th anniversary. The nurses in this program who are serving 127 congregations across northern North Dakota and Minnesota have 1273 years' nursing experience and 330 years' experience as faith community nurses collectively. These nurses are well connected in their denominations, communities, and across the state. Because they have held leadership positions in nursing programs, hospitals, skilled nursing facilities, and professional associations they are sought out to serve on boards and they help define approaches for programs at local, regional, and state levels.

The majority of FCNs in the Sanford program offer blood pressure screening monthly in their congregations and coach individuals to make lifestyle changes that can reduce their risk of developing cardiovascular complications. Providing education sessions on health topics such as: heart disease, cancer, diabetes, and end of life planning is common. These nurses collaborate with community partners to host flu shot clinics, blood drives, and health fairs. The FCNs promote improvement in health and well-being by providing counseling on medications, lifestyle,

physical activity, and screenings recommended for various ages and genders. Congregants feel more confident in making life transitions as the FCN is one consistent person who journeys with them as they move from home, to assisted living, and into skilled nursing facilities. The specific programs and services offered are based on an assessment of the congregation, as well as on the personal and professional experiences of the faith community nurse and the health cabinet members who support this ministry.

## Integrating Faith and Health

Deaconess Phoebe, trusted by the Apostle Paul to deliver his letter to the Romans, is often referred to as the first faith community nurse. "I ask you to receive her in the Lord in a way worthy of his people and to give her any help she may need from you, for she has been the benefactor [minister] of many people, including me" (Romans 16:2 NIV). FCNs establish a health cabinet and develop volunteers to blanket congregants with prayer, presence, and practices rooted in the denominational tradition to help them through their pain and suffering. These nurses are concerned with the whole person; they understand that all of life is spiritual.

Hope and meaning are fashioned by our physical, emotional, spiritual, financial, and intellectual well-being. Illness affects our spirit and our spirit affects our physical health. For example, most nurses have witnessed the impact of cancer on a patient's physical health as well as their spirit, cognition, and interpersonal relationships. One of the most common interventions of the faith community nurse is being fully present, actively listening to the emotion and depth in the congregant's personal story, and then gently guiding him or her toward God's grace. Being a spiritual companion during the tender moments of serious illness has enabled many to express their deepest fears and concerns, lifted the weight of grief, and restored hope, joy, and gratitude for life.

## Preparing for this Specialty

It is an exciting time to be a faith community nurse. Not only does the American Nurses Association recognize this role as a sanctioned nursing specialty, but as of last year the American Nurses Credentialing Center provides an opportunity for these nurses to validate their skills, knowledge and abilities by achieving certification. Registered nurses entering this specialty should have at least 2 years of experience in order to develop health assessment and problem-solving skills. The *Foundations of Faith Community Nursing* classes provide training specifically designed to help interested nurses understand the focus and tasks of this health ministry. The course focuses on the philosophy of faith community nursing, assessment, legal implications of this role, team ministry, and

documentation. The specific content prepares participants for their roles as health educator, personal health counselor, integrator of faith and health, health advocate, referral agent, support group facilitator and coordinator of volunteers.

This fall Sanford Health will launch a ten-week course that starts with a weekend retreat, continues with weekly on-line faculty directed sessions, and culminates with a dedication ceremony. This format will enable licensed registered nurses from all over the region to discern whether this role might be a step in the direction of enabling them to rejuvenate their passion for the art of nursing. Distance will no longer be a barrier; this innovative approach will enable nurses to experience the *Foundations of Faith Community Nursing* course from the comfort of home. To learn more about this course contact Lois Ustanko at [lois.ustanko@sanfordhealth.org](mailto:lois.ustanko@sanfordhealth.org)

## Impact

Faith community nurses are inspired by God's love to serve people in need and to build just, compassionate communities. These spiritually mature nurses are pastorally called to a wholistic practice. Jesus heard the knock and the door is open to nurses who choose this vocation. Faith community nurses address important needs in the lives of people across the lifespan and have the opportunity every day to make a difference in a way that really matters. This may be just the role that will satisfy the longings of your soul.

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# EVIDENCE BASED PRACTICE

## Using pH Paper to Determine NG Tube Placement

**Appraised By:** Samantha Erhardt, SN, Matthew Kopp, SN, Micala Scholz, SN, & Emily Zink, SN (NDSU Nursing at Sanford Health, Bismarck, ND)

**Clinical Question:** Is using pH paper more accurate than air bolus auscultation in determining NG tube placement?

**Articles:**

Boeykens, K., Steeman, E., & Duysburgh, I. (2014). Reliability of pH measurement and the auscultatory method to confirm the position of a nasogastric tube. *International Journal of Nursing Studies*, 51, 1427-1433.

Krafte-Jacobs, B., Persinger, M., Carver, J., Moore, L., & Brilli, R. (1996). Rapid placement of transpyloric feeding tubes: A comparison of pH-assisted and standard insertion techniques in children. *Pediatrics*, 98(2), 242-248.

Fernandez, R., Chau, J., Thompson, D., Griffiths, R., & Lo, H. (2010). Accuracy of biochemical markers for predicting nasogastric tube placement in adults – a systematic review of diagnostic studies. *International Journal of Nursing*, 47(8), 1037-1046. doi: 10.1016/j.ijnurstu.2010.03.015

Turgay, A., & Khorshid, L. (2010). Effectiveness of the auscultatory and pH methods in predicting feeding tube placement. *Journal of Clinical Nursing*, 19(11-12), 1553-1559. doi: 10.1111/j.1365-2702.2010.03191.x

**Synthesis of Evidence:**

Four studies discussing the use of pH paper to determine NG tube placement were carefully assessed. Each study was rated on the strength of their evidence from Levels I to VII, with Level I being a systematic review of random control trials and Level VII opinion of authorities.

Boeykens, Steeman, and Duysburgh (2014) was a prospective observations study that included 331 NG tubes and 314 patients. They compared the results of pH paper and air bolus and auscultation in determining NG tube placement. They state, "In 98.9% of aspirate samples with a pH less than or equal to 5.5,

the tube was located in the stomach. If an aspirate could be obtained, the results of pH measurements showed a sensitivity of 78.4% and a specificity of 85.7%. Obtaining aspirate initially after placement was possible in approximately half of cases but after taking additional measures this increased to 81.6%. The sensitivity of the auscultatory method was 79% while the specificity was 61%," (Boeykens et al., 2014).

Krafte-Jacobs, Persinger, Carver, Moore, and Brilli (1996) was a random-controlled trial that included 68 patients split up into two groups. The first group was 34 patients who had an NG tube and placement was determined by pH and the second group used air bolus and auscultation. They observed, "Ninety-seven percent of patients in the pH-assisted group had successful placement after the first attempt, compared with 53% of patients in the standard group. The average time to successful placement of pH-assisted feeding tubes were 6 minutes. All patients in the pH-assisted group had successful placement after the second attempt, compared with 78% of patients in the standard group," (p, 242).

Fernandez, Chau, Thompson, Griffiths, and Lo (2010) was a systematic review that contained studies that varied in sample size from 36 to 890 patients. This article wasn't able to conclude about the diagnostic performance of the different tests performed.

Turgay and Khorshid (2010) was a methodological study. They conclude that the pH method confirmed 39 correct and 5 incorrect placements which concurred with the X-ray. The auscultatory method had 40 correct and 4 incorrect placements, but the X-ray showed 39 correct and 5 incorrect placements.

Limitations within the articles were identified as a small sample group. The findings of all the studies were consistent with one another that the patient outcome was enhanced by using pH paper to determine NG tube placement rather than using air bolus and auscultation. Therefore, with these positive finding, patient outcome enhanced by using the pH paper method due to more accurate placement and decreased patient complications, such as aspiration pneumonia and pneumothorax.

**Bottom Line:**

The evidence supports using the pH paper method to determine accurate placement of the NG tube.

**Implications for Nursing Practice:**

Nurses can educate the staff on the benefits of using the pH paper method versus air bolus and auscultation. This will improve patient outcomes, provide better nursing care, and an overall decrease in complications.

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# EVIDENCE BASED PRACTICE

## Midnight Removal of Urinary Catheters

**Appraised by:** Alex Lovgren, SN, Shelby Hatch, SN, Julie Perkins, SN and Laura Yokom, SN (NDSU Nursing at Sanford Health, Bismarck, ND)

### Clinical Question:

In patients with short-term indwelling catheters, does timing of catheter removal decrease UTI, re-catheterization and reduce hospital length of stay?

### Articles:

- Ahmed, M.R., Ahmed, W.A., Atwa, K.A., & Metwally, L. (2014). Timing of urinary catheter removal after uncomplicated total abdominal hysterectomy: a prospective randomized trial. *European Journal of Obstetrics & Gynecology and Reproductive Biology*, 176, 60-63.
- Fernandez, R., Griffiths, R., Murie, P. (2003). Comparison of late night and early morning removal of short-term urethral catheters. *JBIR Reports*, 1(1), 1-16.
- Gross, J., Harding-Fanning, F., Kain, M., Faulkner, E., & Goodrich, S. (2007). Effect of time of day for urinary catheter removal on voiding behaviors in stoke patients. *Urologic Nursing*, 27(3), 231-235.
- Kelleher, M.M. (2002). Removal of urinary catheters: midnight vs 0600 hours. *British Journal of Nursing*, 11(2), 84-89.

### Synthesis of Conclusions:

The studies done by Ahmed, Ahmed, Atwa, & Metwally (2014), Fernandez, Griffiths, Murie, (2003), Gross, Harding-Fanning, Kain, Faulkner, & Goodrich, (2007), and Kelleher, (2002) meets scientific criteria and has scientific merit. The evidence of the articles addresses removal of short-term and long-term indwelling urinary catheters and the optimal time to remove catheters after insertion. Each study was rated on the strength of their evidence from Levels I to VII, with Level I being a systematic review of random control trials and Level VII opinion of authorities. The levels are those modified by Melny & Fineout-Overholt (2005).

The first study by Ahmed, et al. (2014) is a level II hierarchy of evidence randomized controlled trial. The purpose of this study was to assess whether immediate (0h), intermediate (6hr), or delayed (after24hr) removal of an indwelling urinary catheter can affect the rate of re-catheterization due to urinary retention, rate of urinary tract infection, ambulation time, and length of stay. The findings showed that immediate removal of urinary catheters after surgery had a far greater chance of re-catheterization. Delayed removal had a greater chance of urinary tract infection, late ambulation, as well as a longer duration of hospitalization. From the study conducted, intermediate (6hr) removal of the catheter has shown to be the best choice in removal of catheters because there was far less complications with this option.

The second study by Fernandez, et al. (2003) is a systematic review with eight randomized and quasi-randomized control trials and a level I hierarchy of evidence. The purpose of this review is to find the significance between removing a short-term indwelling urinary catheter (IUC) in the late night versus early morning. The systematic review revealed that patients that have their IUC removed in the late night have a higher first void volume and the length of stay was decreased. However, when removing the IUC at night the time between removal and first void is greater, generally occurring in the

morning when the patient gets up. The findings did not show any correlation between removal time and having to catheterize because of urinary retention.

The third study by Gross, et al. (2007) conducted a level II randomized two group comparative design – quantitative study. The purpose of this study was to compare the effect of urinary catheter removal at 7:00 a.m. with removal at 10:00 p.m. on the length of time to first void, the amount of the first void, post-void residual urine, and the number of subjects requiring re-catheterization. The average ages for this study were 70.3 years old and have had their catheters in place for an average of 18.2 days. This study shows that there were no significant differences between the two groups on time to void, volume voided, or post-void residual but nine of the forty-five patients needed re-catheterization after being catheterized.

The fourth study by Kelleher (2002) is a random control trial and is a level II hierarchy of evidence. The purpose of this study was to determine whether there was a relationship between the time of catheter removal and return to normal voiding patterns. Also, whether it had any impact on the time and date of discharge from the hospital. The time of the first and second void and volume of both voids between the two groups was statistically significant. Sixty-four percent of patients in the midnight group were discharged from the hospital on the same day as compared to the 0600 group with only twenty-three percent being discharged on the same day.

Each study was of high quality. Each reached similar conclusions that removal of short-term indwelling catheters during nighttime hours will decrease length of hospital stay. The studies also revealed that time to first void was later and volume of first void was larger. The sample sizes of each study had a large enough population for statistical significance and used appropriate statistical measures to analyze their data.

### Bottom Line:

There is sufficient evidence to suggest that nighttime, 10:00 pm to 12:00 am, removal of short-term indwelling catheters would benefit patient outcomes and decrease length of hospital stay. Also, intermediate removal, 6 hours post catheterization, for patients has a greater impact than immediate or late removal. A nurse-driven protocol would need to be in place for the new policy to be effective.

### Implications for Nursing Practice:

Nurses working in areas with patients that require a short-term indwelling catheter can use the evidence from the studies to support the implementation of removing catheters during the nighttime hours of 10:00 pm and 12:00 am.



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# Burnout: What Staff Nurses Need to Know!

Teri Alderson, S.N.  
Minot State University

Have you ever felt the exhaustion from being overstretched emotionally or felt like the weight of the world is on your shoulders? Sometimes we experience situations that suddenly arise but dissipate quickly leaving us exhausted. However, it may feel never-ending if the passion for nursing has led to staff nursing in a long-term facility or acute hospital. One study surveyed 95,499 nurses and concluded that there is "much higher job dissatisfaction and burnout among nurses who were directly caring for patients in hospitals and nursing homes than among nurses working in other jobs or settings, such as the pharmaceutical industry" (McHugh, Kutney-Lee, Cimiotti, Sloane, & Aiken, 2011). This type of exhaustion results from "prolonged disparity between what the person gives and receives in the workplace" (Nicol, 2011). Literature frequently reports many nurses hanging up their stethoscopes because of disillusionment, which can also lead to health problems.

Staff nurses must avoid burnout and safeguard against becoming a statistic by abandoning this amazing profession. Considering the years of grueling preparation, financial investment, and incredible dedication required to be a nurse, it is important to identify ways to protect oneself against this disturbing reality. Fortunately, literature has identified three key themes that may be a solution: Problem-focused coping, emotion-focused coping, and emotional intelligence (Nicol, 2011).

There is a strong relationship between coping style, personality traits, and burnout suggesting certain individuals experience less stress and susceptibility to burnout. While it may not be

possible to change personality traits, the good news is that it is possible to develop better coping skills. Problem-focused coping strategies such as time management, organizational skills, and seeking advice from others all help with stress management. The key is using energy reserves to enhance internal feelings and self-control. Those who sense control by external forces, are more likely to experience the negative affects of stress. Research shows, "Burnout is specifically connected to the work environment and occurs when the individual feels ineffectual in their workplace, resulting in the loss of purpose and the meaning that was once attached to his or her work" (Nicol, 2011).

Positive emotion-focused coping is another strategy of internally regulating emotional responses to problems (Nicol, 2011). Evidence shows that reflection through writing leads to well-developed self-awareness. Over 90 studies examined how reflective writing positively impacted blood pressure, immune functioning, asthmatic symptoms, and depression (Lee & Cohn, 2009). In expressive writing, participants write about a specific stressful event 15-20 minutes per day for 3-4 days giving personal insight into a problem, thus integrating problem-focused and emotion-focused coping.

Emotional Intelligence involves competence in self-awareness, self-management, social interactions, and relationship management (Sullivan, 2013). Self-awareness, the ability to process, understand, and manage personal emotions, especially in relationships, is a key concept emotional intelligence (Nicol, 2011). With the constant exposure nurses have to emotional situations, the ability to be introspective and self-reflective is critical for coping with burnout. As self-awareness increases so does the ability to

manage and use emotions appropriately so that the root problem is clearly addressed.

In a study examining the relationships between self-control and health, less self-control is associated with avoidance coping leading to incidences of adverse physical symptoms (Boals, vanDellen, and Banks, 2011). Avoidant coping style examples include: denial of stressors, avoiding emotions, and turning to work or activities to avoid stressors. Individuals with higher self-control are less likely to avoid problems resulting in lower rates of depression, alcohol abuse, fewer sore throats and sneezing, and higher levels of satisfaction with life.

Staff nurses need to identify personal coping strategies, develop greater self-awareness and emotional intelligence to experience less stress and less susceptibility to burnout. The result may be fulfilling the purpose and calling in life that led to this profession in the first place.

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# United Nations and the Commission on the Status of Women

Mary Margaret Mooney, PBVM, DNSc, RN, CS, FAAN is currently a representative to the UN for the NGO International Presentation Association and submitted the following article. She was able to participate in most of the nursing sponsored events mentioned in the article.

The United Nations (UN) has existed for 70 years and its Commission on the Status of Women (CSW) is in its 59th annual session. Over that time nurses have been involved with the UN in its humanitarian and policy support work. Nurses as individuals also have been part of the work of non-governmental organizations advocating for international policies and activities that promote physical and mental health. For example, the current chair of the NGO Health Committee at UN Headquarters in New York is a nurse.

Yet, despite the congruence of core values of nursing with the founding purposes of the United Nations and the similarity of CSW goals to the aspirations of the nursing profession, this is the first year that nurses as a professional group have had an official voice paralleling a UN meeting. The annual meeting of CSW took place March 9- 14, 2015, in New York City and during that time nursing organizations sponsored four parallel events: a reception attended by Judith Shamian, President of the International Council of Nurses (ICN) and many nurses from around the world and three workshops, *a) Empowering Women Through Education, b) Creative Interventions Addressing Critical Health issues in the Post-2015 Agenda and c) Future directions to Ensure Health & Mental Health for Girls & Women.* The events were sponsored by New York area Sigma Theta Tau chapters, ICN, the Nightingale Initiative for Global Health and other organizations.

Perhaps the old adage, "well begun, half done," applies to this "first for nurses" and in coming years the profession of nursing will continue to have a corporate voice at the UN. Not only because they comprise the largest group of health professionals but also because they are trusted promoters of holistic well-being, nurses have much to offer the international community.

Two continuing education credits have been approved for American nurses for the on-line program, *The World Nurses Want: A Global Briefing.* The program and other information can be found at [www.theworldnurseswant.net](http://www.theworldnurseswant.net).



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